Review of ICW CPS Cases Bremerton Division of Children and Family Services

Introduction

Following the deaths of Justice and Raiden Robinson, the Division of Children and Family Services (DCFS) Regional Administrator arranged for a review of the child protective services (CPS) investigations of referrals assigned to the Indian Child Welfare (ICW) unit in the Bremerton DCFS office.

CPS in Region 5 has for a many years conducted periodic reviews of CPS investigations. In each of these reviews, full compliance with Children's Administration policies and procedures is measured. The questions asked in these reviews have been modified over the years as additional requirements and expectations have been added to CPS social workers.

The reviewers were experienced CPS supervisors, program managers and an area administrator from the Tacoma DCFS office. Although these reviewers were employed in the same region as the social workers assigned to the cases reviewed, they were not in the same chain of authority until the regional administrator level. They were asked to use the same judgment and critical view of cases as they have used historically in case reviews.

Background

The Bremerton DCFS office was primarily under the authority of an area administrator responsible for all programs in the office, with the exception of several programs that were centralized in the region under another area administrator. One of those centralized programs was services to children and families who were believed to be of American Indian descent. There is an Indian Child Welfare unit in Tacoma and one in Bremerton. It is the expectation of these units that they work closely with Tribes and that they meet the standards of the Indian Child Welfare Act, which require very active efforts in preventing placement of children and reunifying children if placed in out-of-home care.

The ICW unit in the Bremerton DCFS office included two positions responsible for investigating referrals to CPS on Indian children. Prior to the deaths of the Robinson children, workload had been identified as a significant problem for the ICW CPS social workers in the Bremerton office. In addition to the number of referrals assigned, a backlog of cases had developed that had not been closed, though services were no longer active. A process was developed to "bump" ICW CPS referrals to the other two units in Bremerton that investigated CPS referrals if too many referrals were received in a given month (over ten). However, despite this procedure, the backlog of cases that had not been finished in addition to new CPS referrals assigned still was posed a significant workload for the staff in the ICW CPS units

There had also been considerable turnover in the ICW CPS positions. One worker, at the time of the deaths of the Robinson children, had been a CPS worker for two years. The other position had been vacant and the newly employed worker had just completed the training required in

order to investigate referrals and provide services at the time the Robinson children died. The previous worker who held that position had only worked for a little more than a year prior to transferring to another office nearer his home. The cases that were reviewed had been assigned to this worker who had left the office at the time of the review.

Review

The review asks a number of questions, all based in DCFS policy and procedures. Two caseloads were reviewed, based on the two positions in the unit. A number of problems were identified, including one case that we felt required additional investigation and resulted in an opening of services to the family.

A total of 54 cases were reviewed representing referrals that had been received and investigated between January and August 2004. Some cases had more than one referral during this time period. Position #1 had 32 cases reviewed. Position #2 had 22 cases reviewed. The discrepancy had to do with the turnover in Position #2 and that the position was vacant for a period of time during the period in which investigations were reviewed.

Results

Considerable deficiencies were noted in the practice of the Bremerton ICW CPS unit. The problems in the investigations and documentation of the information led to difficulty accurately assessing risk to the children. The most notable deficiencies were:

- There were delays in interviewing and observing children, or failures in seeing all the children named in a CPS referral as possible victims.
- The social workers made insufficient collateral contacts to get input into the children's safety and well-being. Collateral contacts should be made with relatives, professionals and Tribes who have knowledge of the child's and/or family's situation.
- Referrals for additional assessments were often not made when indicated.
 - For those families requiring safety plans to protect children, some of the plans developed did not fully respond to the short and long-term risks identified either in the referral or through the investigation.
- There was insufficient service delivery to the families to mitigate the risks of abuse or neglect. This included not regularly seeing children in out-of-home placement.
- There was insufficient shared decision-making on cases, including insufficient use of Child Protective Teams.
- There was delayed and insufficient documentation of case notes and investigative risk assessments. Investigative risk assessments describe the risk to the children

upon completion of the investigation and short-term service delivery, if there were services offered.

Changes since the Review

Once the DCFS Regional Administrator received the results of the review, a change plan was initiated to improve the quality of investigations in the Bremerton DCFS office, both for the ICW units and for the non-ICW CPS investigative units. It was important to plan for all CPS units in Bremerton because of the turnover in all CPS units.

The change plan consisted of the following steps:

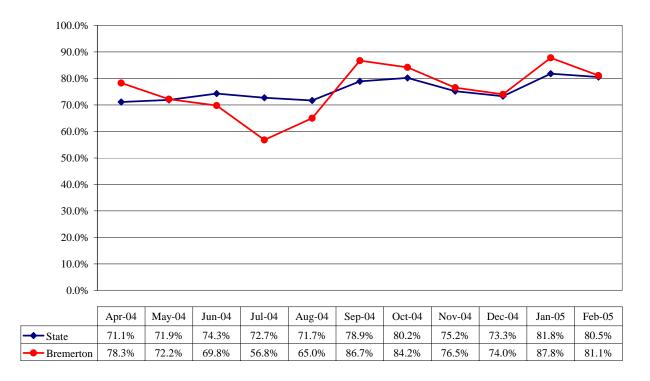
- An experienced area administrator with expertise in CPS was reassigned to the Bremerton DCFS office to create the change plan and to temporarily supervise the CPS and intake functions in the office.
- The two ICW CPS positions were reassigned to the CPS units in Bremerton. This put all CPS staff under the supervision of two experienced CPS supervisors.
- Increased training was offered CPS staff in risk assessment, safety planning, and the high standard of investigation requirements.
- A Social Worker 5 (this position provides training and takes on lead-worker responsibility in units) was reassigned to provide more training to the new staff being hired, allowing supervisors to spend more time monitoring the work completed.
- A project focused on families with non-emergent neglect issues was terminated, bringing two staff back to the CPS units to handle investigations of CPS referrals.
- The CPS area administrator has become involved with supervisors and staff in screening decisions concerning child protective service referrals to ensure their accuracy, thoroughness, and that correct decisions were made.

Staff report that morale has significantly improved in the last several months. They report they feel more involved in the problem-solving, are receiving better training, and have more support from the regional administration. This improved morale seems to be reflected in fewer staff resigning their positions. No employee has resigned in the last three months, since this plan was initiated.

It is also positive that improvement can already be seen in the statistics from the office in the data gathered routinely by the department to measure compliance with policies and procedures. The positive results of this effort have been seen in the increase in the number of children seen within required time frames. One of the Bremerton CPS units leads Region 5 in percentage of children seen within required time frames and the other is making significant progress in this area.

Ten-Day Face-to-Face Compliance

(referrals in which all alleged victims are seen within 10 days)

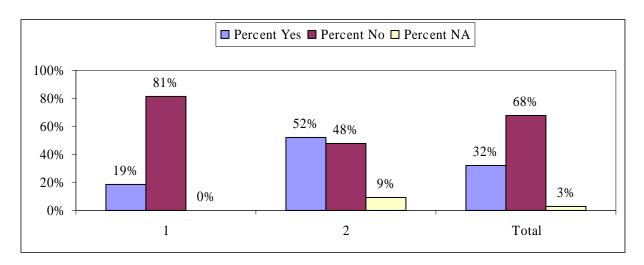


Staff in Bremerton CPS have much to be proud of in the progress they have shown since this review. In the next few months, the Regional Administrator will determine managerial assignments and expectations to continue this improvement plan and to implement the Kids Come First Phase II changes that are anticipated for CPS in the coming fiscal year.

Review Results by Question

The following are the questions asked in the review, which are questions from the standard case review format used by Children's Administration from 2001 through 2004 for CPS case reviews.

Question 1: Were all child victims identified in the referral interviewed within 10 working days of the referral date by the investigating social worker or another professional?

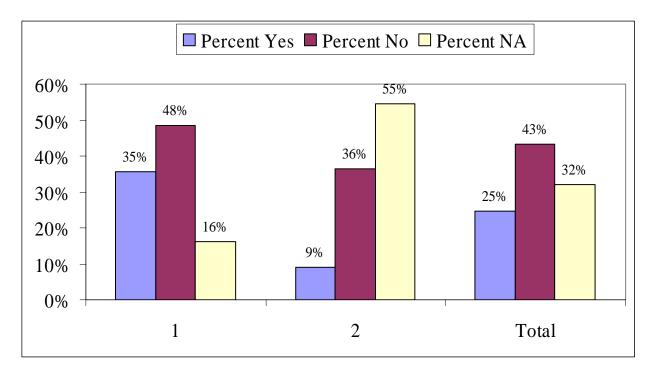


In order for this question to be answered "yes" all children identified as possible victims in the referral must be seen and interviewed or, if nonverbal, observed within ten days from the receipt of the referral. A number of issues can interfere with this process including delays in receiving the referral from intake, difficulties in finding the family, and difficulties in seeing all the children (though some may have been seen).

If no, how many days beyond 10 days did the contact occur?

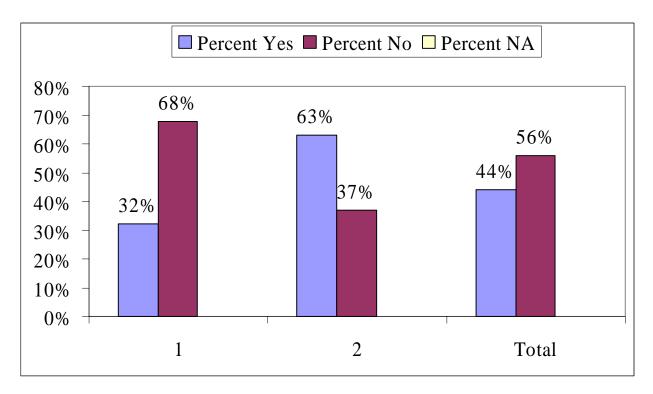
Position	1	2	Total
% 0 - 10	9%	20%	12%
% 11 - 30	9%	0%	6%
% 31 - 50	4%	10%	6%
% 51 - 70	4%	10%	6%
% 70 +	17%	20%	18%
% Never	57%	40%	52%

Question 2: If the child is determined to be Native American was the tribe notified of the CPS investigation and input?

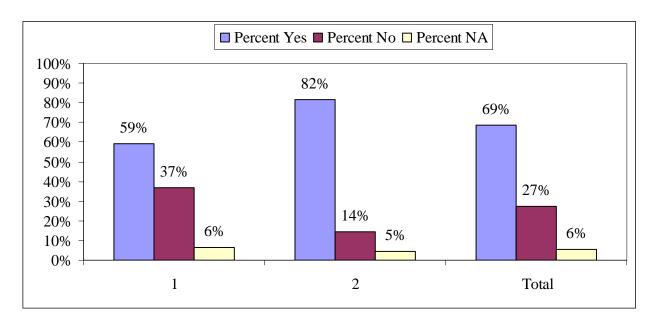


Note: While the children assigned to the ICW CPS social workers for investigation of referrals were all identified as having Native American heritage, upon further inquiry it was determined that many of the children were not eligible for membership in a tribe. Thus, 32% of the cases did not require notification to a tribe.

Question 3: Were sufficient collateral contacts made consistent with the high standard of investigation?

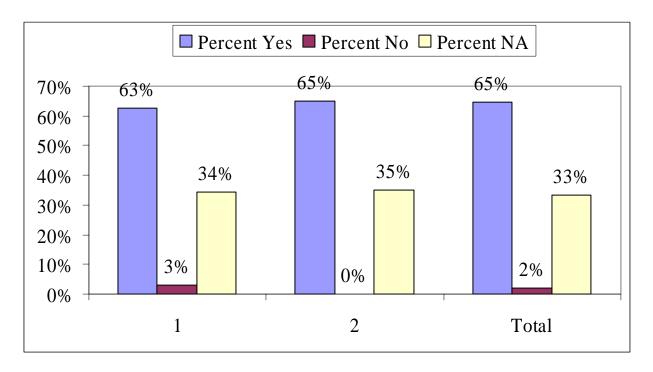


Question 4: Was the safety assessment completed within required timeframes?

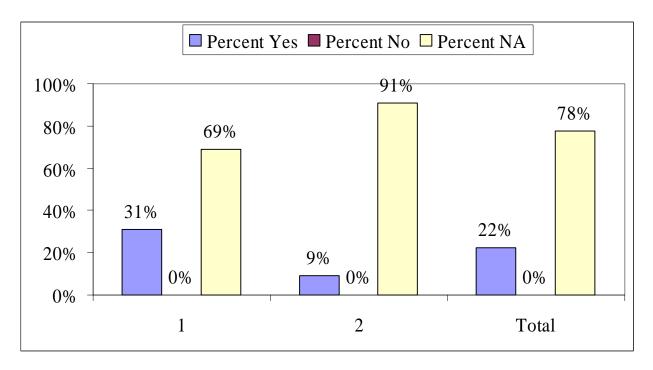


Note: Those cases in which this question was not considered applicable are those families that could not be located.

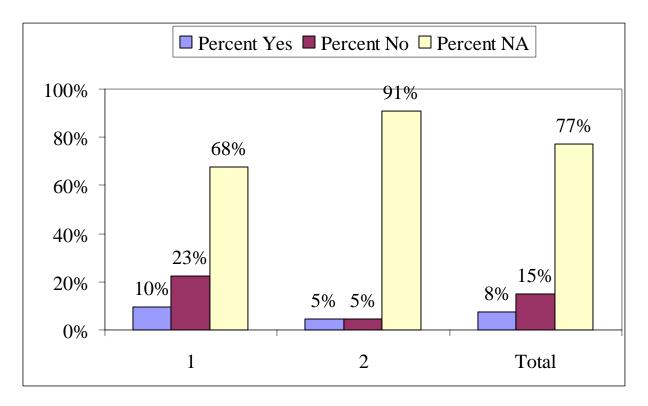
Question 5: If a Safety Assessment was completed, did the Safety Assessment adequately indicate all serious and immediate harm to the child?



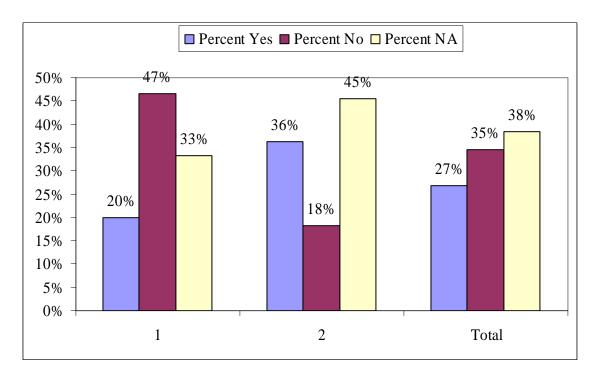
Question 6: If the Safety Assessment had a response marked "indicated", was a Safety Plan completed?



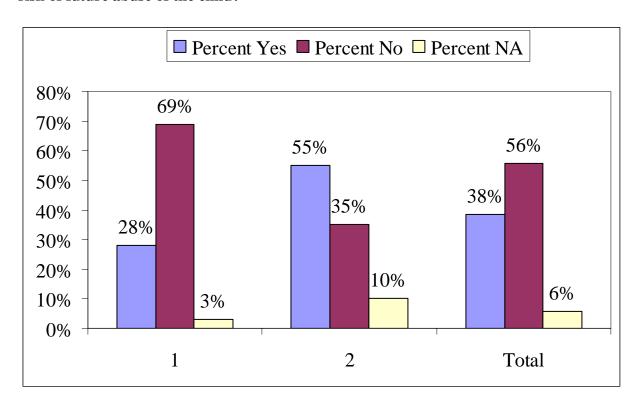
Question 7: If a Safety Plan was developed, did the Safety Plan adequately address the serious and immediate safety concerns for the child?



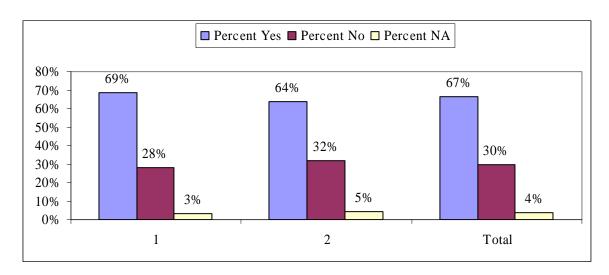
Question 8: Was appropriate action taken to ensure the safety of the child during the investigation (safety plan established, services provided, legal or placement)?



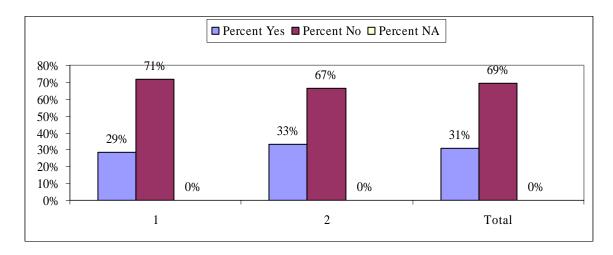
Question 9: Was the information gathered during the investigation adequate to assess the risk of future abuse of the child?



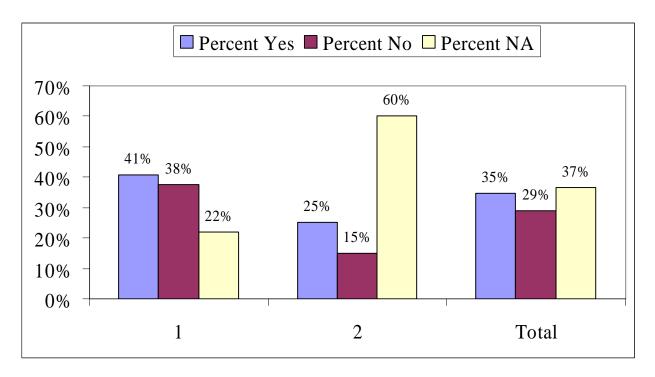
Question 10: Were all subjects interviewed?



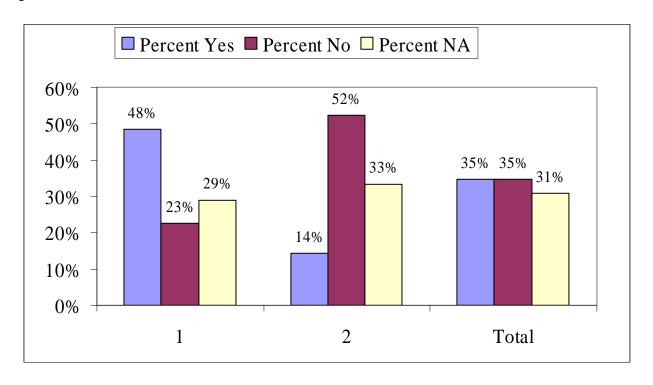
If NO or NA, did the worker make and document efforts?



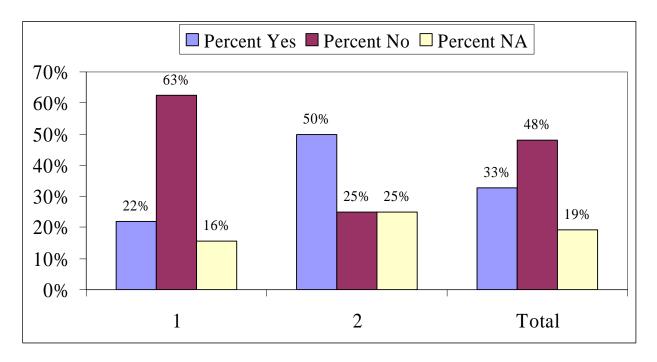
Question 11: Were professional assessments obtained to determine the service needs of the parents/caretakers?



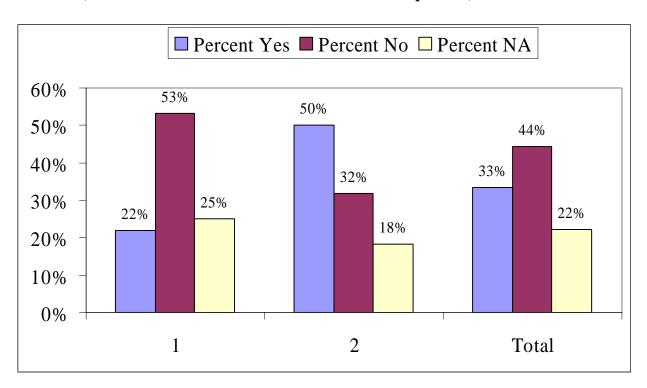
Question 12: Are there any additional assessments that should have been obtained for the parents/caretakers?



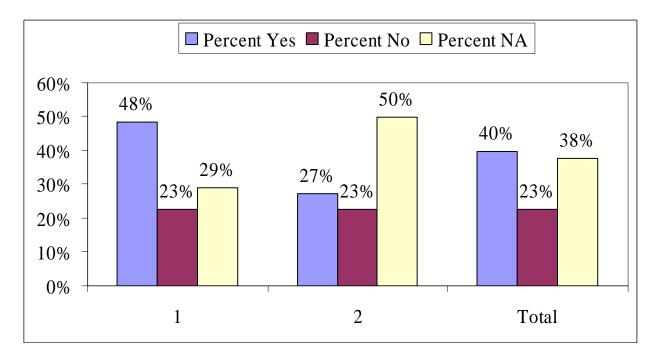
Question 13: Were appropriate services offered and/or provided to the family?



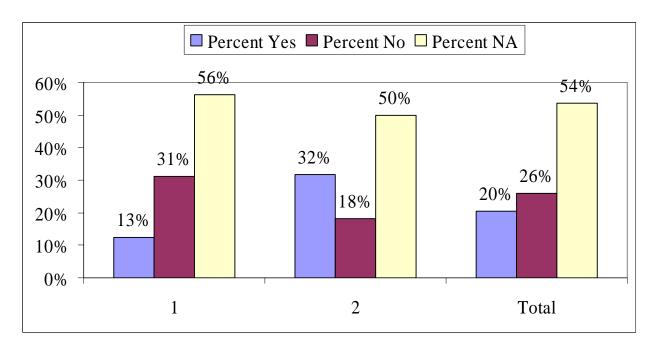
Question 14: Were the impacts of the CA/N and/or caretaker characteristics on the child assessed? (Did the social worker describe how child was impacted?)



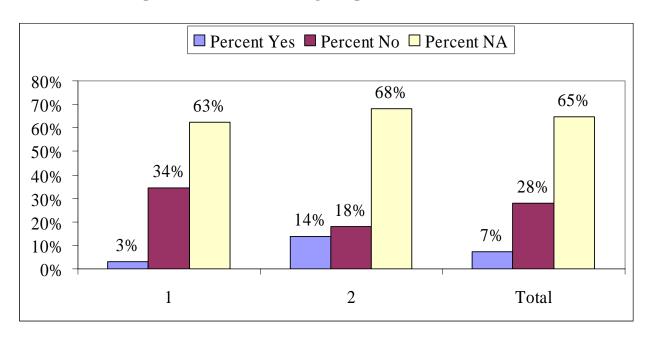
Question 15: Were appropriate services offered and/or provided to the child? (e.g. medical, dental, mental health, educational)?



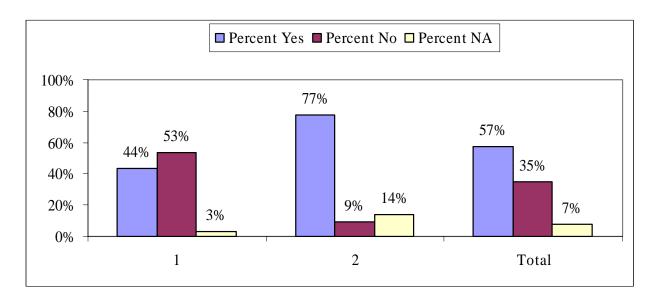
Question 16: Did services provided to the family while open to CPS reduce risk to the children?



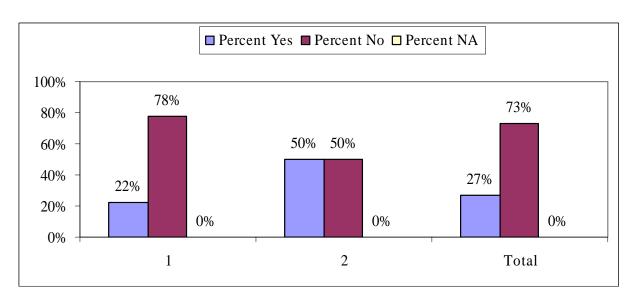
Question 17: If required, was a CPT staffing completed?



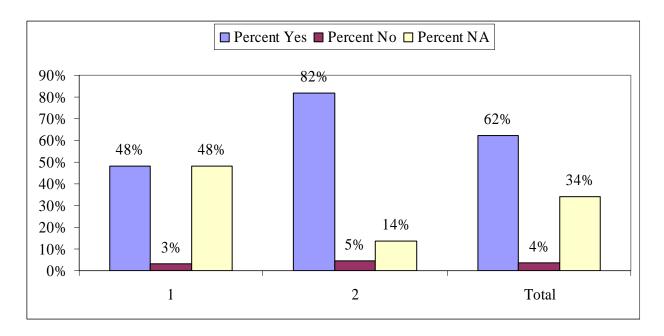
Question 18: a) Was the Investigative Risk Assessment completed within 90 days for moderate risk and above referrals?



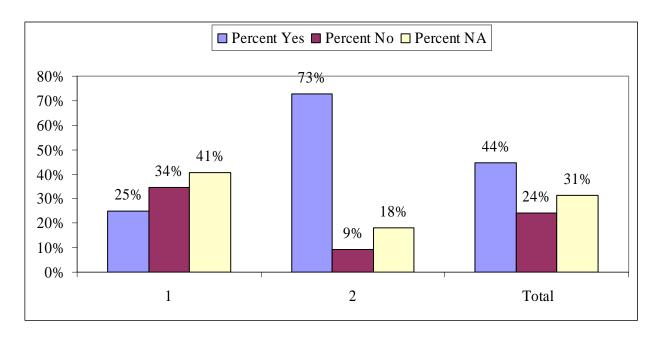
Question 18: b) If NO, was it done within 120 days of referral date?



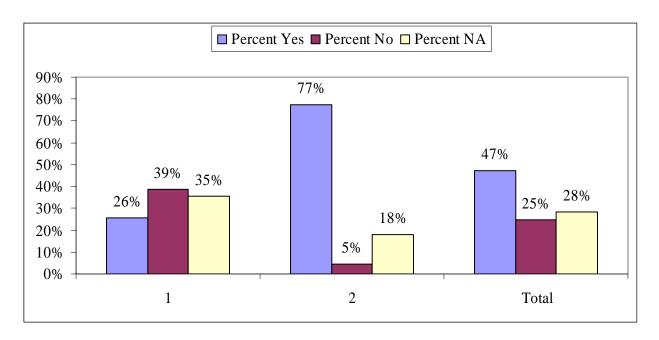
Question 19: Is a history of child abuse or neglect is reflected in the current summary assessment?



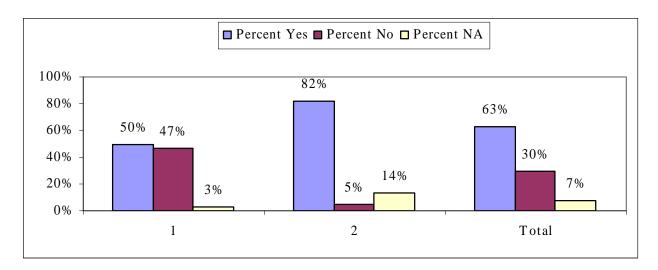
Question 20: Were the findings made supported by documented information in the case file?



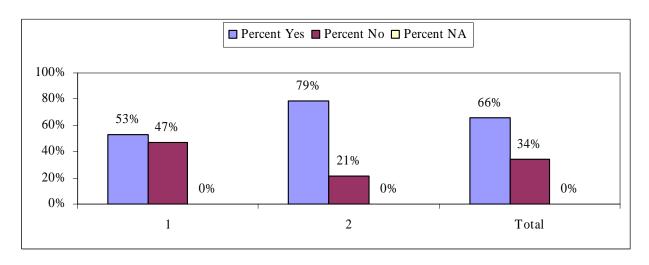
Question 21: Was overall risk tag on investigative assessment supported by documentation?



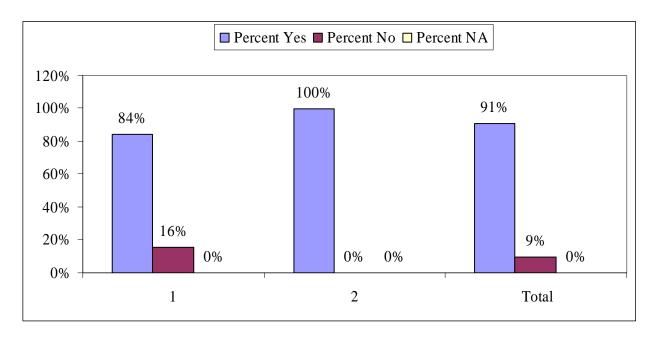
Question 22: Has the CAPTA letter been sent? (Note: this is the letter sent to parents informing them of the outcome of the investigation. This is required by the federal Child Abuse Prevention and Treatment Act. Families who disagree with a finding that abuse or neglect has occurred may request a review and a hearing with an administrative law judge.)



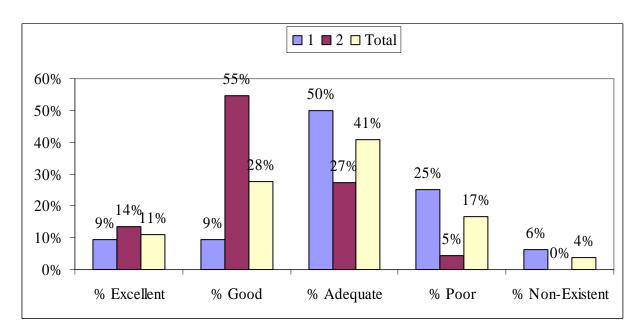
If yes, was it sent out within 90 days of the referral date?

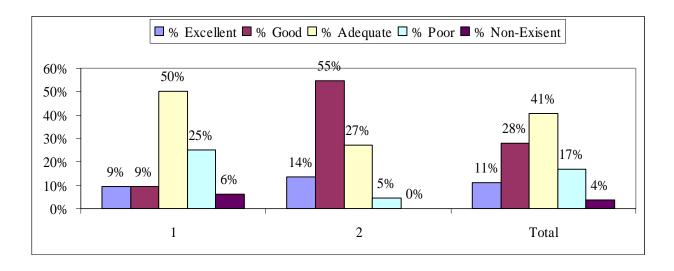


Question 23: Is there evidence of supervisory review in the record? (Note: These reviews, especially if there has been a delay in recording case notes in the management information system, are reliant upon the verbal descriptions/reports of the social workers.)

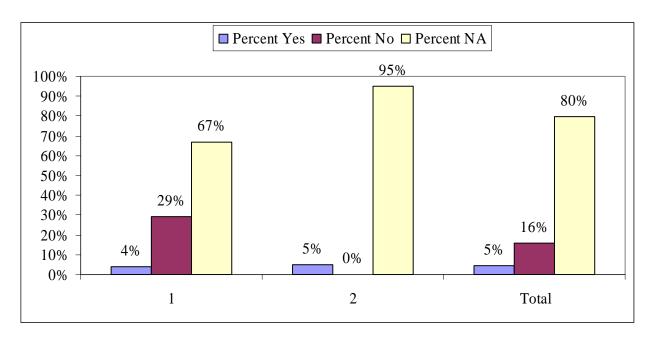


Question 24: Rate the overall case work documentation.





Question 25: If the child has been in placement more than 90 consecutive days, has a health and safety visit been completed in the foster home with the child and the child's placement parents?



Question 26: Has a comprehensive, ongoing relative search been documented in the case file if the child has been in care more than 72 hours?

